

# Dental Benefits

Administered by Delta Dental Plan of Colorado

Good oral care enhances overall physical health, appearance and mental well-being. Problems with the teeth and gums are common and these health problems can be easily treated. Keep your teeth healthy and your smile bright with the City of Englewood dental plans.

| City of Englewood Group #1656               | PLAN A<br>Delta PPO Network  | PLAN A<br>Premier or<br>Non-Participating | PLAN B<br>Delta PPO Network  | PLAN B<br>Premier or<br>Non-Participating |
|---|--|---|--|---|
| <b>Network Information</b>                  | <b>PPO DENTIST</b> – Payment is based on the PPO allowable fee, or the actual fee charged, whichever is less.<br><b>PREMIER DENTIST</b> – Payment is based on the premier maximum plan allowance, or the fee charged, whichever is less.<br><b>NON-PARTICIPATING DENTIST</b> – Payment is based on the non-participating Maximum Plan Allowance. Members are responsible for the difference between the allowable and the full fee charged by the non-participating dentist. |   |  |   |
| <b>Calendar Year Deductible</b>             | N/A  | N/A                                       | \$50 Individual<br>\$150 Family  | \$50 Individual<br>\$150 Family           |
| <b>Calendar Year Maximum Benefit</b>        | \$2,000 Per Person Per Calendar Year<br>(Covered Diagnostic & Preventive Services do not count toward your calendar year maximum.)   |   | \$1,000 Per Person Per Calendar Year<br>(Covered Diagnostic & Preventive Services do not count toward your calendar year maximum.) |   |
| <b>Orthodontia Lifetime Maximum Benefit</b> | \$2,000  |   | N/A  |   |
| <b>Exams</b>                                | 100% — 2 Per Calendar Year   |   | 100% — 2 Per Calendar Year   |   |
| <b>Prophylaxis (Routine Cleaning)</b>       | 100% — 2 Per Calendar Year   |   | 100% — 2 Per Calendar Year   |   |
| <b>Bitewing X-ray / Full Mouth</b>          | 100% — Bitewing = One Set Per Plan Year.<br>Full Mouth = Once Per 60 Months  |   | 100% — Bitewing = One Set Per Plan Year.<br>Full Mouth = Once Per 60 Months  |   |
| <b>Basic Restorative</b>                    | Plan Pays 100%   | Plan Pays 80%                             | Plan Pays 80% (Deductible Applies)   |   |
| <b>Extractions</b>                          | Plan Pays 100%   | Plan Pays 80%                             | Plan Pays 80% (Deductible Applies)   |   |
| <b>Periodontics</b>                         | Plan Pays 100%   | Plan Pays 80%                             | Plan Pays 80% (Deductible Applies)   |   |
| <b>Endodontics</b>                          | Plan Pays 100%   | Plan Pays 80%                             | Plan Pays 80% (Deductible Applies)   |   |
| <b>Crowns</b>                               | Plan Pays 50%  |   | Not Covered  |   |
| <b>Surgical Implants</b>                    | Plan Pays 50%  |   | Not Covered  |   |
| <b>Dentures</b>                             | Plan Pays 50%  |   | Not Covered  |   |
| <b>TMJ</b>                                  | Plan Pays 50%  |   | Not Covered  |   |
| <b>Orthodontia</b>                          | Plan Pays 50%  |   | Not Covered  |   |

**Important Note:** This provides only a brief description of services covered under your contract and does not list those services which are limited or excluded from coverage. Your Delta Dental Booklet provides a more complete explanation of your coverage, including limitations and exclusions. If differences exist between this summary and your Delta Dental Booklet, the Booklet will govern.

Please refer to the Company Corner on the Marketplace for specific details regarding our dental plans.

